Chapter 4

Assessment of Child Crime Victims

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Introduction

Child victims deserve timely and skilled assessment of how the crime has affected their lives and what will help them recover. The initial clinical assessment provides the basis for developing an effective crime-related treatment plan. However, child and adolescent crime victims present distinct challenges to the mental health evaluator. Initial referral is often driven by a traumatic event, rather than by specific symptoms in the child. Clinicians most commonly diagnose posttraumatic stress disorder (PTSD) in these clients; a diagnosis characterized by symptoms of reexperiencing, numbing and avoidance, and hyperarousal (DSM-IV: APA, 1994). However, child and adolescent crime victims frequently develop other disorders instead of (or comorbid with) PTSD (Schwab-Stone et al., 1999) which clinicians might overlook. These include affective disorders such as depression, adjustment and anxiety disorders (Singer, Anglin, Song & Lunghofer, 1995); behavior problems (Martinez & Richters, 1993) and dissociative disorders (Putnam, 1997). Children traumatized by crime can also exhibit avoidant symptoms, cognitive distortions, emotional distress, impaired sense of self, academic problems and interpersonal difficulties (Briere and Elliot, 1994). Developmental factors influence the clinical expression of symptoms. Finally, caregiver capacities must be considered in reaching a comprehensive view of the child's functioning and resources. This chapter focuses on initial mental health assessment of child crime victims, including diagnosis and treatment planning.

Assessment Goals

The goals of mental health assessment following a crime-related traumatic event include:

- Evaluate the child's overall functioning following the crime.
- Determine if the crime or subsequent crime-related events have impaired the child's functioning.
- Develop an initial working diagnosis.
- Identify strengths and resources to support recovery.
- Identify potential barriers to recovery.
- Determine the need for mental health treatment.
- Develop an assessment-informed treatment plan.

The task force recommends a multi-method, multi-source approach that includes both qualitative and quantitative information. The evaluator should assess how the child functioned before the crime, the effects of the crime itself, and what coping skills and resources are available to support recovery. The quality of the initial assessment depends on the sensitivity and skill of the evaluator, as well as the youth's willingness to communicate about traumatic experiences to an unfamiliar adult.

Mental health assessment is conducted for the purposes of diagnosis and treatment planning; it is not conducted to determine whether a child has been the victim of a crime. However, assessment can evaluate whether the child or adolescent has psychological injuries typically seen as the result of trauma, and the clinician is likely to form some opinion about what occurred. Although information about a crime could be disclosed and documented during the initial mental health assessment, the acquisition of such information is not the evaluator's task. Forensic interviewing to gather evidence of a crime is a specialized role that is generally incompatible with the role of clinical evaluator. Although the roles of clinical evaluator and

forensic interviewer sometimes blur when crimes involve very young children (Hewitt, 1999), it is clinically, legally and ethically advisable to keep the roles separate whenever possible.

Event Factors

The relationship between a traumatic event and associated trauma symptoms is affected by a number of factors. The frequency, duration and severity of symptoms vary widely in response to direct victimization (Kendall-Tackett, Williams, and Finkelhor, 1993), and indirect exposure to family or community violence can produce detrimental effects comparable to direct victimization (Saigh, 1991). Some events, such as those including the use of force, severe physical injury, and life-threats are more likely to have a greater effect on child victims (Foy, Madvig, Pynoos & Camilleri, 1996; March, Amaya-Jackson, Terry & Costanzo, 1997). However, the effects of a traumatic event may also be modified by individual factors including age and gender (March, Amaya-Jackson, Terry & Costanzo, 1997; Schwab-Stone et al., 1999; Joseph, Brewin, Yule & Williams, 1993), family factors (Boney-McCoy & Finkelhor, 1996), and other aspects of the traumatic event (Foy, Madvig, Pynoos & Camilleri, 1996).

While intrafamilial traumatic events create complex relationship problems which differ from those found in trauma from non-related offenders, exposure to violent crimes and other community violence also place children at high risk for developing posttraumatic distress symptoms (McNally, 1993). These symptoms can be relatively prevalent among youth exposed to traumatic events (Berman et al., 1996). Exposure to multiple violent events is also associated with posttraumatic distress symptoms (Horowitz et al., 1995), and the consequences of exposure to multiple violent events can be cumulative (Pynoos and Nader, 1988).

Coping with Trauma

Not all young crime victims develop psychiatric problems requiring mental health treatment. Some cope by relying upon family, friends, and religious and community resources. The quality of a child's family support system and the child's own coping strategies are the best indicators for successful recovery following a traumatic event. One of the most salient factors in the child's recovery from abuse is the ability of their caregiver to provide emotional support (Cohen & Mannarino, 1996, 1998). Caregiver impairment due to depression, substance abuse, personality disorders, or other factors is associated with higher levels of symptom development in the child (Browne & Finkelhor, 1986; McFarlane, 1988).

Several studies have found that younger children are more likely to develop posttraumatic distress symptoms (Davidson and Smith, 1990; Fitzpatrick and Boldizar, 1993; Hoffman and Bizman, 1996) but the results are inconsistent (Green et al., 1991; Garrison et al., 1993). However, subsequent stages of child development can be adversely affected by trauma at earlier stages (Berliner and Wheeler, 1987).

Children may be more sensitive to trauma than adults because they have not developed an established identity, and their repertoire of coping behaviors is more limited (Gil, 1991). Symptom onset in children can also be delayed until triggered later by developmental events such as the physical changes of puberty (van der Kolk, 1987). Children who are exposed to traumatic stress can experience changes in autonomic functioning (Perry, 1994), regulation of stress hormones (DeBellis et al., 1994), and neurophysiological functioning (Ornitz & Pynoos, 1989). Lack of self-regulation is one of the most far-reaching effects of psychological trauma. The younger the child and the longer the duration of trauma, the more likely children are to have problems with managing anger, anxiety and sexual impulses (van der Kolk, 1996).

A child's emotional and cognitive responses to a traumatic event are likely to change with increased maturity and social awareness. Due to these developmental changes, effective therapy with children is often an intermittent rather than continuous process. Many children reach points where they have worked on the trauma as much as they are able for their level of cognitive and social development. However, they may need additional trauma-related treatment at later developmental stages.

Children and adults having a close relationship with a trauma victim are more likely to develop posttraumatic stress symptoms (Pynoos et al., 1987; Martinez and Richters, 1993). Research among adolescents has found that exposure to violence in the home is associated with greater levels of symptoms than exposure to violence in the community or at school (Singer et al., 1995).

Differences between girls and boys in the development of posttraumatic distress symptoms have been found by some researchers (Green et al., 1991; Shannon et al., 1994; Berton and Stabb, 1996; Shaw et al., 1996; Stein, 1999), but not others (Pynoos et al., 1987; Burton et al., 1994; Shaw et al., 1995). Similarly, boys may be more likely to have higher rates of non-sexual violence exposure (Fitzpatrick and Boldizar, 1993; Berton and Stabb, 1996), but these findings are not conclusive (Cooley et al., 1995).

Little is known about the cognitive factors which influence the development of emotional disturbance in children following trauma, despite a strong emphasis on such factors in the adult literature (Foa & Jaycox, 1999). However, some preliminary work has been done to explore the role of cognitive factors in post-trauma adjustment. An examination of attributional style found that children who made more internal causal attributions about negative events had greater posttraumatic stress symptoms one year later (Joseph et al., 1993). An external locus of control has also been found to be associated with PTSD symptoms in children (Joseph, Brewin, Yule & Williams, 1993).

Symptom Specificity

The child who is brought for treatment of symptoms following trauma must be evaluated as a developing individual with a history and a present context. It is important to remember that not everything about the child is directly related to the traumatic event. Understanding the child's earlier life experience is necessary for planning and focusing treatment. With this in mind, the clinician can distinguish between trauma-related symptoms and general symptoms.

General Symptoms

General symptoms are those which can be detected at the time of trauma assessment but which probably preexisted the trauma. Some of those symptoms could have occurred even without trauma, even if family and life context had always been optimal. Examples include the symptom constellations described as learning disability, or as Attention Deficit Hyperactivity Disorder (Barkeley, 1997; Casey et al., 1997) or Pervasive Developmental Disorder (Tanguay, Robertson & Derrick, 1998).

General symptoms can also arise from prior context patterns or concerns. These are symptoms that stem from accumulated life experience, such as having a depressed parent (Field et al., 1988; Tronic & Weinberg, 1997) or living in a chaotic, over-stimulating environment. Examples of such symptoms include neediness, inability to trust, aggressive externalizing behavior, or distorted social attributions (Cicchetti & Toth, 1995; Cicchetti & Tucker, 1994). The treatment plan should address these symptoms even as it focuses upon symptoms specific to the trauma that the child experienced.

Trauma-Specific Symptoms

Trauma-specific symptoms are those which are related to the trauma itself. The constellation of symptoms which comprise PTSD would be an example of such symptoms. In fact PTSD is one of the few symptom complexes which is pathognomic for trauma; most other emotional and behavioral sequelae of trauma can have multiple etiologies. However, there are trauma sequelae that both our experience and reason lead us to suspect may be present and these are given special attention in the trauma assessment. Those sequelae include disorders of mood or anxiety, neurovegetative disturbances, and behaviors referred to as sexualized or abuse-reactive (Briere, 1995; Friedrich, 1996; Gil & Johnson, 1993; Bonner et al. 1999).

General or Preexisting Symptoms Exacerbated by a Crime

As a practical matter one cannot always reliably distinguish between general and specific symptoms when conducting an initial assessment. The pre-trauma history is often sketchy, and the children themselves are not the best historians of their own development. In addition, the distinction between general and specific symptoms can be blurred when the trauma exacerbates a preexisting condition that was subclinical before the trauma into a necessary focus of treatment. For instance, a child with a shy, reserved temperament can become reclusive after a trauma; a child with a tendency toward mood instability can become acutely labile; and an adolescent who engaged in experimental or occasional use of drugs or alcohol can become a habitual user.

The mental health evaluator may not be able to make an exact distinction between general and specific symptoms in formulating the initial treatment plan. Any symptoms which are serious enough to impede recovery from the trauma must be a focus of treatment, whatever their etiology. As treatment progresses, distinctions between general and specific symptoms can become more important. Symptoms which appear more refractory to trauma specific treatment should be evaluated for the possible contribution of preexisting factors in their etiology. A treatment plan which does not take adequate account of congenital or endogenous factors in symptom formation, or which overlooks the contribution of significant others in the living environment, can lead to misdirected effort and a delay in recovery, to the detriment of the child.

When the crime is not recent, or when the onset of symptoms or treatment is delayed, the mental health evaluator should be particularly cautious about attributing all presenting problems solely to the traumatic event. The evaluator should distinguish between the etiological significance of the trauma and other factors that contribute to the child's current difficulties.

The Assessment Process

The mental health evaluator should seek information from multiple sources, including:

- Review of case records
- Observation and interviews with the child or adolescent
- Interviews with primary caregivers
- Collateral contacts, such as teachers and physicians
- Standardized testing

Review of Case Records

Many evaluators prefer to form their own impression of a client, uninfluenced by other opinions and conclusions. However, repeated interviews about crime information pose the risk of secondary traumatization to a child. The reports described below can be helpful in providing relevant case history, including detailed information about the crime.

Previous Mental Health Assessments and Treatment Reports

Records of previous mental health treatment can be useful in comparing a child's functioning before and after a crime. The following questions should be considered:

- What was the modality and duration of the previous treatment?
- Was treatment terminated due to lack of progress, problems with attendance, poor motivation on the part of the child or their caregiver, or for other reasons?
- Has the child been previously diagnosed with any developmental delay, learning disability, or major psychiatric disorder that could affect crime-related treatment?
- Has the child been identified as having been the victim of any prior child abuse, neglect or other trauma?

- Has the child been treated with psychotropic medications?
- Was previous treatment related to the same or a different crime, and were treatment interventions trauma-focused or more general in nature?

Law Enforcement Reports

Law enforcement reports often include the child's first statements about the crime, identity of the reporting party, witness statements, location of the crime, characteristics of the crime, identity of the offender, and occasionally an offender confession. Law enforcement jurisdictions differ as to whether they release crime reports to evaluating or treating therapists. Some mental health evaluators may not have access to crime reports due to legal considerations.

Medical Reports

The medical report describes who initiated a physical exam (parent, youth, child welfare services, law enforcement), the location and duration of the exam, findings about physical injuries, whether physical evidence of a crime was obtained, and statements made by the child (and caregiver) to medical personnel about injuries. Some traumatic events result in permanent disability. The type, severity and prognosis of a disability can be obtained from medical reports and physician consultation. The psychological impact of any follow-up medical care should be considered in the mental health treatment plan (for example, follow-up testing for pregnancy, HIV or sexually transmitted diseases). It is also important to understand crime-related injuries and to determine their relationship to the child's recall of events.

Child Welfare Reports and Court Orders

Child welfare reports and court orders contain information regarding family composition, dynamics, and history, as well as whether the child was removed from their parents, what charges of abuse or neglect were filed with the court, and what charges were sustained. Confidentiality concerns can make it difficult to obtain public child welfare records. However, most mental health evaluators have the right to be informed regarding case history and court orders. For more information, see the chapters on "Court Dependent Children," "Public Child Welfare," and "Legal Issues."

If the court has made specific orders for treatment, the evaluator must consider these orders in developing a treatment plan for the child. If the court orders appear to be in conflict with the best interests of the child, the mental health evaluator can play an important role working collaboratively with the child welfare agency and the court to achieve a plan that is more consistent with the child's needs and capacities.

Court-Ordered Mental Health Evaluations

Reports by neutral, court-appointed evaluators can be useful in complex cases, as they often include assessments of the parent and family, in addition to psychological assessment of the child victim. They can inform the mental health evaluator of psychiatric problems, substance abuse, or family dysfunction. Court-ordered evaluations should be viewed cautiously when young children are assessed in a limited number of sessions. It is not unusual for young children to deny or fail to disclose abuse in interviews with an unfamiliar adult (Hewitt, 1999). In addition, parents in court cases are generally motivated to present themselves in the best possible light. Mental health evaluators must have the court's authorization to obtain court-ordered evaluation reports, unless the child's parents or attorney make these reports available.

Clinical Interviews with Child and Adolescent Crime Victims

Mental health assessment of children and adolescents requires good communication skills and a genuine interest in young people. Their natural reluctance to trust unfamiliar adults is heightened by victimization. The clinician must be skilled in assessing developmental level and general cognitive, emotional and behavioral functioning. In addition, the clinician must assess the impact of traumatic events and identify crime-related problems. Assessment techniques should be tailored to the age and developmental level of the young victim and may include direct observation, diagnostic questions, mental status examination, directed

and nondirected play, and projective techniques (such as art and writing exercises). Whenever possible, assessment should occur in the child's primary language.

Older children or teenagers are typically more comfortable talking to an evaluator without their parents in the room, but younger children need time and direct support to separate from caregivers. It is helpful to familiarize children and parents with the office, restroom locations, where to get water, and so on. Younger children need to know where the primary caregiver is waiting while they are with the evaluator, and they may also need to see them occasionally in order to manage anxiety and tolerate the separation.

When meeting a child or adolescent for the first session, the evaluator should ask what the child knows about the purpose of the meeting. Older children and teenagers are often concerned about what happens to the information they provide. The concept of confidentiality should be explained in a manner that fits the child's ability to understand. Do not promise children a degree of confidentiality that cannot be legally or ethically sustained. Children do not need to know the legal language of the Child Abuse Reporting Law, but they do need to know that there are situations when the evaluator must talk to parents or other adults to ensure safety (for example, if the child might hurt themselves or if they have been hurt by someone else).

Assessment methods used and recommended treatment plans are influenced by a child's cognitive functioning and developmental level. An estimate of the child's cognitive functioning and developmental level can be done informally, through conversation, observation and caregiver reports about the child's school performance. Are the child's vocabulary and language skills consistent with their age and grade level? Does the child appear regressed or developmentally delayed as they interact with caregivers or other children? When clinical observation suggests a cognitive or developmental problem, a more comprehensive assessment of these domains is recommended.

The evaluator should assess the child's mental status, including affect, mood, and behavior. With children who have been crime victims, it is especially important to watch for verbal or behavioral indicators of anxiety, hyperarousal, fearfulness, avoidance, and dissociation. These symptoms can interfere with the child feeling safe and comfortable enough to respond to evaluator questions.

To cope with anxiety, traumatized preschool children may withdraw, hide under furniture, report somatic complaints, ask for food, or leave to use the restroom. Older children and teenagers are more likely to use verbal avoidance techniques such as silence, opposition, or changing the subject away from distressing topics. Traumatized children may also have trauma-related problems with distractibility, hyperactivity and poor attention skills which can result in a misdiagnosis of Attention Deficit Hyperactivity Disorder. Impaired stimulus discrimination and attention skills may also be a reason for the high co-morbidity between Posttraumatic Stress Disorder and Attention Deficit Hyperactivity Disorder in traumatized children (Putnam, 1995).

Children often are detached or emotionally numb following a crime, and the only obvious distress is disturbance in physical routines such as eating and sleeping. Several weeks may be needed following a crime before more lasting impacts can be assessed. Some traumatized children display irritability or anger as a result of poorly modulated aggression (Pynoos et al., 1996). Others — often due to sexual trauma — display sexual behavior that does not match their age or developmental level (Friedrich et al., 1992).

One of the more controversial issues regarding interviews with child and adolescent crime victims is whether specific inquiry about the crime is necessary for the evaluation process. The appropriateness of crime-specific interviewing depends on many factors, most importantly the child's own desire to reveal this information to the evaluator. Some children come to assessment wanting to talk about many aspects of their traumatic experience and associated feelings. In one clinical case, a twelve-year-old boy described in detail the domestic violence beating of his mother, along with his own memories of how terrified he was and his 911 call to the police (Winterstein, 2001). However, not all children are ready or able to tolerate the anxiety of talking directly about the crime. A two-year-old girl who was found between the bodies of her parents in a family homicide case could not provide a coherent narrative of the events, but instead threw a doll against the wall and repeated the phrase "They got shot. They all dead." (Winterstein, 2001). The evaluator should

be sensitive to the child's level of anxiety when doing any questioning about crime-related events. The child's willingness to talk about the crime should not be a requirement for therapy, nor should therapy be focused on obtaining crime disclosures from children.

The assessment process can precipitate negative reactions such as agitation or anxiety as the child remembers and reexperiences the traumatic event. An evaluator who expects to refer a child to someone else for therapy must use clinical judgment about how much emotionally charged material a child should be encouraged to discuss during initial assessment. The child will have to repeat much of the same material with the treating therapist, and there might also be a delay between assessment and treatment. The assessment process should not leave the child with increased anxiety and inadequate therapeutic support.

Event Factors

The following event factors should be considered when assessing child and adolescent crime victims, although the information may need to be obtained from the caregiver interview and from case records, rather than from the child.

- Type of traumatic event (school violence, community violence, witnessing domestic violence, family homicide, physical abuse, sexual abuse, chronic neglect)
- Severity and proximity of the event
- Perceived life threat
- Identity of the offender
- Relationship of the offender to the child
- Age of child when the event(s) occurred
- Frequency (single event or repeated events)
- When and how the traumatic event was discovered.
- When and how the traumatic event was stopped or resolved
- Other traumatic events in the child's history
- Other stressful conditions in the child's life

Children's Reports of Their Own Symptoms

Clinicians should ask children directly about their perception and understanding of what happened to them. They also should be asked — in words tailored to their age and developmental level — to describe any problems they are having because of what happened. A child's appraisal of an event is an important source of information in determining traumatic impact. However, at times children may minimize or exaggerate in relation to the actual facts or what might be expected to follow such an event. Both kinds of presentations require careful assessment.

Caregivers are also an incomplete source of information regarding how a child is feeling and coping. Parents may either deny or overestimate the impact of trauma on their children. Following traumatic events, children and adolescents may have concerns or symptoms that they have not revealed. At times they are protective of parents and do not wish to burden them with additional problems. Adolescents may question whether adults can be relied upon to help them. Younger children lack the ability to spontaneously report on how they are doing. The younger the child, the less capable he or she is of engaging in internal reflection on subjective experience or of spontaneously providing verbal descriptions of distress. However, if asked directly, children and adolescents often reveal multiple concerns and distress symptoms about which their parents may not be aware.

Children frequently have sleep disturbances after trauma, including sleep avoidance, restlessness, talking in their sleep, and nightmares. Chronic sleep disturbance causes children to be irritable during the day and can result in problems with concentration and attention, contributing to impaired school performance (Pynoos,

1996). Child and parent reports about the child's sleeping patterns should be compared. While not always precise about time, children and adolescents can usually describe if they have trouble falling asleep, if they wake up during the night, if they have bad dreams, and what they do to get back to sleep.

Most elementary school children understand the idea of dreams and can describe specific dream content and whether the dreams are "good" or "scary." Even some preschool children understand the concept that dreams are like a movie in their heads and can draw pictures of their nightmares. It is not unusual for traumatized children and adolescents to have repetitive crime-related dreams. These dreams are often troubling and are a common factor in sleep avoidance in traumatized children. When asked if they have any ways of avoiding frightening dreams, many children describe staying awake as long as possible or watching television late into the night.

Young crime victims are often fearful and may need reassurance that most people have worries or fears after a crime. Children and adolescents should be asked directly about things they are afraid of because of the crime, as well as things they were already afraid of before the crime. Younger children can be asked to make something out of Play-Doh or clay, or to draw pictures of things they fear. Adolescents are less comfortable admitting fears but often respond to projective techniques that allow them to acknowledge both the brave and fearful parts of themselves, such as drawing a strong, outside self that they show the world and, on the reverse side, a self with feelings they don't want people to know about. Older children and adolescents can often engage in more sophisticated self-report assessment tasks, such as rating their fears on a scale or identifying fears which they consider either likely or unlikely to occur.

Evaluators should ask children and adolescents about intrusive thoughts; this is a reexperiencing symptom that children rarely describe spontaneously but often acknowledge in response to direct inquiry. The clinician can explore intrusive thoughts by asking if the child has times (while they are playing, in school or with friends) when unwanted thoughts come into their heads. Children may describe not wanting to think about the crime but find themselves unable to stop thinking about it. Children can also be asked about dreams or nightmares that they think about while they are awake. Coping strategies can be assessed with follow-up questions about the methods children use to stop intrusive thoughts.

Children and adolescents have difficulty recognizing and reporting dissociative behaviors, since by definition dissociation implies detachment from cognition and emotions. Clinicians can ask children and adolescents if they ever daydream, "space out," or go to another place in their mind when they feel upset or scared. Some children describe this process readily, including descriptions of what they think about or where they go in their heads to feel safe. Others are unable to respond to these inquiries and the clinician must rely on clinical observation, caregiver report, or standardized measures.

Direct inquiry about changes in toileting functions (enuresis or encopresis) may not elicit truthful information due to the social embarrassment and the fear of punishment that children expect when they cannot control bodily functions. In fact, children often hide wet or soiled clothing to avoid detection. Clinicians must rely primarily on caregiver or teacher reports to identify this symptom. In some child crime victims, these symptoms occur during episodes of dissociation, when the child becomes numb or detached from body sensations. It is important to gather adequate history to determine whether the problem has developed or been exacerbated following the crime, or if it was preexisting. Clinicians tend to associate enuresis and encopresis specifically with sexual trauma. However, children can display these symptoms for other reasons, and they should be evaluated by a physician to rule out a medical etiology.

Assessment of Crime-Related Issues

Clinicians view traumatic events through an adult perspective and may make inaccurate assumptions about a child's thoughts and feelings. The skilled evaluator will try to elicit the child's perceptions, thoughts and feelings about the traumatic event, recognizing that the memories and attributions of meaning that are most salient and disturbing to the child may not be immediately evident to the evaluator. Like adults, children can misremember the time sequence or details of a traumatic event. Due to magical thinking and egocentrism,

they may develop distorted attributions about causality or their own responsibility in the crime. Winterstein (2001) described clinical cases involving distorted attributions about causality. In one case, a child who witnessed a domestic homicide developed a belief that it was his fault that his mother was killed, because the fatal argument started over his poor report card. In another case, an adolescent injured in a shooting thought it was a punishment from God for her experimentation with drugs and tarot cards. In a third case, an elementary school boy who was molested by a neighborhood pedophile felt guilty that his "best friend" went to jail, even though the offender's conviction was caused by evidence other than the child's statements.

The evaluator tries to determine how the child makes sense of the events that have occurred. Does the child have an explanatory cognitive framework for the troubling events that have happened to them? Did the child fear that they would die or be seriously harmed? The child's beliefs about why the crime occurred and perceptions of the offender play an important role in the child's sense of safety from future harm. The evaluator should ask what the child thinks should happen to the offender. Do they think the offender should be punished, and if so, what punishment would the child consider to be fitting to the crime. In crimes where the child knows the offender, it is important to ask what kind of contact the child currently has or wants to have with the offender. Although this information should not be the basis for a decision about contact, it can reveal important clinical information about the child's perceptions.

With both known and unknown offenders, children may feel fear or even anger because their parents were unable to protect them from the crime. The evaluator can explore how the child thinks their parents found out about the crime, what steps did the parents take, and how safe the child feels with the parents now. Children often have intrusive thoughts or nightmares about retribution from offenders, in which they and their family members are harmed. It is important to know if children view their caregivers as a source of help and protection from future harm, or if they view the parents as being at the mercy of future actions by the offender.

It is important to ask children and adolescents about their experiences with the medical, child welfare, law enforcement and court systems. What do they remember about those contacts and how do they describe their experiences? For example, an evaluator may find that an adolescent rape victim is having intrusive thoughts about a remark made by the physician during the forensic medical exam. Young victims often draw or write perceptively about their experiences with the "investigative" and "helping" systems.

Some child and adolescent crime victims are greatly stressed by court involvement, with increases in anxiety and PTSD symptoms. Others gain a sense of mastery, increased confidence and a sense of justice from participating in the prosecution of their offender. Lack of familiarity with the courtroom and court procedures can cause stress to both children and parents. If the offender is not convicted of the crime, it is important to ask the child's understanding of this and how (or if) it was explained to them. For information about preparing children for interactions with the judicial system, see the work of Saywitz et al. (1993).

Assessing Danger to Self

"Suicidal behavior in children is any self-destructive behavior that has the intent to hurt oneself seriously or to cause death" (Pfeffer, 1986). The rate of suicide in youths fifteen to nineteen increased 14% from 1980 to 1996, but even more alarming is the 100% rate increase for children ten to fourteen (Surgeon-General, 1999). Child suicide statistics are estimates at best, since it is often difficult to determine whether a child's death was intentional or accidental. There is a strong correlation between depressive disorders and suicidal behavior in children, with the risk of suicide increasing with the severity of depression.

Suicidal children six to twelve years old use methods that are impulsive in nature, involving readily available dangers: jumping from heights, taking household poisons, hanging themselves, running into traffic, jumping out of moving cars, or drowning (Pfeffer, 1986). These methods can increase the difficulty of differentiating between accidental and intentional injury or death. Depressed and suicidal children are often "accident prone" and require close supervision and monitoring to ensure their safety. While little empirical data is available, this task force considers victimized children and adolescents to be at increased risk for suicide

when they are clinically depressed, substance abusing, or when discovery of their maltreatment results in blaming of the victim or brings unwanted consequences to their offender.

Although female teens attempt suicide in greater numbers than males, adolescent males use more lethal methods and are far more likely to die from suicide attempts (Centers for Disease Control, 1996). Adolescent suicide is associated with depression, substance abuse and impulsivity in response to situational stress. Teenagers kill themselves primarily in response to common problems of daily living for which they can see no viable solution (for example, the break-up of a relationship, failing a school test, or family problems). The emotional and legal pressures brought on by victimization can further exacerbate the typical stresses of adolescence.

All mental health assessments of children and adolescents should inquire about guns in the household and the client's access to guns, as they are by far the greatest risk to teenagers as a suicide method (Centers for Disease Control, 1986). The next most commonly fatal methods of suicide for adolescents are self-strangulation (hanging), drug overdose, or poisons such as carbon monoxide. When assessing children and adolescents in cases of trauma, the therapist should do the following:

- Ask them directly if they have thoughts about hurting or killing themselves.
- Ask if they have thought of a method or developed a plan for killing themselves
- Ask if they have taken any specific steps to accomplish the plan, or if they intend to do so. Be attentive to behavioral indicators of plans in process.
- Explore how they think discovery of their victimization will affect their lives and the lives of their family and friends in the future.
- Assess elements of hopelessness, self-blame or a sense of fatalism and negativity about the outcome of system interventions
- Identify any previous family history of suicide. In a small number of cases, offenders commit suicide before arrest or while incarcerated. In such cases, especially when the offender is a family member or friend, intervention and assessment of the victim with consideration of their own suicide risk is critical.
- Assess whether the youth has had friends, classmates or family members kill themselves, because young people are at higher risk during the period following the completed suicide of a family member or peer (Brent et al., 1995).

Assessing Danger to Others

Assessment of whether a child or adolescent presents a danger to others is challenging and far from an exact science. Accurate prediction of violence remains one of the most difficult tasks for the mental health professional. It is fairly common for young people to have thoughts or fantasies about hurting themselves or others. For example, crime victims often have fantasies of revenge against their offenders. However, the vast majority of youth never follow through on these thoughts. When assessing danger to others, the clinician must consider specific risk factors. The best predictor of future violence is a past history of violence. Other risk factors associated with higher levels of violence include the following:

- Prior behavioral problems such as arrests and truancy
- Violent family members and relatives
- Use of alcohol and other drugs
- School underachievement

When assessing whether a child is planning to harm another person, clinicians should do the following:

- Determine the degree of development of the child's thoughts or fantasies.

- Determine whether the child has moved beyond vague ideas toward the development of specific plans.
- Assess the seriousness of their plan.
- Assess whether the child has carried out any action to implement the plan, such as looking for a gun or ammunition.
- Assess the progress of the plan. What other steps they have taken? What remains to be done? When do they anticipate doing it? As a youth moves from a vague plan to concrete actions, a clinician's level of concern and response should increase proportionally.

Although the majority of children and adolescents who report suicidal or violent thoughts do not go on to harm themselves or others, clinicians should always take suicidal statements or threats of violence seriously. California's *Tarasoff* decision (and subsequent precedents) have established an absolute duty to warn if a threat has been expressed toward a "reasonably identifiable" person or group of persons. Based on this, if your client has expressed any intent or plan to harm a specific person or persons (including themselves), you must:

- Contact anyone you believe to be in danger.
- Contact parents or caregivers to warn of the danger.
- Contact a county or private psychiatric emergency team (especially in a case of danger to self), to obtain an evaluation for hospitalization.
- Contact law enforcement (especially in a case of danger to others).

For more information on the clinician's obligations to report danger to self or others, see the *Tarasoff* section in the "Legal Issues" chapter.

Assessing Need for Psychiatric Referral

Behavior that presents a reasonable risk to either the child or someone else should lead a clinician to consider a psychiatric referral and possible hospitalization. Such behaviors include suicidal statements or indicators, threats, violent plans, or impulsive risk-taking behavior.

Low to moderate levels of anxiety or depression often improve in response to psychotherapy. However, if a child has symptoms of thought disorder, severe anxiety or depression, or other mood disorder, the optimal treatment may be a combination of pharmacological and psychological interventions. A psychiatric referral should be made unless there is a compelling and documented clinical reason to defer medication evaluation.

Assessing Disturbance in Sexual Behavior

Disturbance in sexual behavior is a commonly reported clinical symptom in children and adolescents with sexual abuse and multiple maltreatment histories. Several studies have found that sexually abused children engage in more sexual behavior than non-abused children (Einbender & Friedrich, 1989; Friedrich, Grambsch, Damon, et al., 1992; Kendall-Tackett, 1993). The Child Sexual Behavior Inventory (CSBI) is a caregiver report measure that can be helpful in assessing reports of sexual behavior problems in children (Friedrich (1997)). The CSBI differentiates between behaviors that are normative based on the child's age, and behaviors that are atypical and suggestive of abuse history or other variables such as exposure to sexually explicit activity or materials. In assessing caregiver reports of disturbed sexual behavior in children, the evaluator must distinguish between what sexual behaviors are commonly observed in non-traumatized children and what sexual behaviors are cause for clinical concern. *Understanding Your Child's Sexual Behavior* (Johnson, 1999) can assist clinicians and caregivers in developing an informed understanding of which reported sexual behaviors are normal, and which may be potential problems to be considered in the child's treatment plan.

Clinical Interviews with Primary Caregivers and Collateral Contacts

Assessment of a child crime victim should include a clinical interview with the child's parents or primary caregivers to obtain information about the child's history, symptoms, and relationships. This also provides an opportunity to engage the caregivers in planning the treatment process. They play a pivotal role in supporting the child's recovery and should be considered an integral part of the intervention team. Mental health professionals have limited contact with children, and their best efforts can be undone by a parent or caregiver who does not support the intervention plan.

Parents are usually emotionally distressed by the crime against their child, even if they have some responsibility for the harm that has been done. Clinical interviews may be experienced by parents or caregivers as intrusive, as they may have been interviewed already by investigators and other professionals. The interviewer should take time to build trust and rapport with a caregiver. Explain the purpose of the interview and the parent's central role in helping the child. Begin the interview in an open-ended manner by asking the parents to describe their concerns and observations about their child, and what they are expecting from the assessment process. Some parents begin talking immediately about the trauma and its impact on the child and family. They feel better if they can discuss the most difficult material right away and respond to a good listener who allows them to talk about the trauma history with few interruptions. Other caregivers are more avoidant and need a carefully structured interview, beginning with general questions about the child's history and leading toward more focused, crime-related questions as the interview progresses.

A caregiver may not be able to provide accurate information about a child's history and functioning. At times, parents are unable or unwilling to provide relevant information for a variety of reasons. Foster parents may lack information about a child's medical, developmental or family history. It is useful — with appropriate authorization — to seek information about children from teachers, pediatricians, extended family, child welfare workers, child care providers and other adults who know the child.

Psychosocial, Developmental & Family History

The interview with the child's parents or caregivers should include the basic elements of a psychosocial history, including:

- Client demographic information
- History of the child's presenting problems
- Current family and household structure
- Names, ages and locations of siblings
- Developmental history
- School placement and functioning (social and academic)
- Friendship relationships and leisure activities
- History of previous mental health treatment
- Child and family use of alcohol or drugs
- Family history of medical or mental health problems
- Family socioeconomic status
- Client, family and neighborhood stressors and strengths

The evaluator should identify the important relationships in a child's world, such as parents and caregivers (including biological, step and foster parents), siblings, grandparents, cousins, and family pets. Information should be obtained regarding family deaths or separations, pet losses, and the impacts of these losses on the child. The evaluator should ask about positive sources of family, friendship or neighborhood support for

both the child and caregivers, and also explore psychosocial stressors such as finances, neighborhood problems or transportation difficulties in attending medical, mental health and court-related appointments.

Developmental and medical histories should include prenatal history, circumstances of birth, and any history of illness, injury, surgery or medications during infancy and childhood. Normal developmental milestones should be noted, such as walking, talking, and toilet training. For further information about medical, developmental and psychosocial assessment, see Sattler (1998) and Aylward (1994).

Assessment of Crime-Related Issues

A primary goal of assessment is determination of the parent or caregiver's capacity to emotionally support the child. This requires gaining an understanding of how the caregiver understands the crime and views the child's difficulties. Does the caregiver possess the capacity and willingness to respond in a helpful way to the child's symptoms? If they are not able to be helpful, can they be neutral or benign? Ask the caregiver to explain in their own words what happened to their child. It is not uncommon for the parent or caregiver to describe the crime in a way that differs substantially from investigative and medical reports. Ask the caregiver to distinguish among the following:

- What they observed directly
- What the child said to them
- Information gained from others

The evaluator should note any significant discrepancies between the parent's understanding of the crime and that obtained from other sources. It may not be clinically appropriate to point out discrepancies in the initial interview, but the evaluator can form hypotheses about them. Miscommunication can occur between parents and investigators or other professionals. In some cases, the child may attempt to protect the parent's feelings by withholding information about the traumatic event. In other situations, parents or caregivers give a different account because they are emotionally overwhelmed or in denial about the severity of the crime against their child. Some parents minimize events to cope with guilt feelings about their perceived failure to protect their child. Others have their own trauma histories which they may be reluctant to reveal, but which make it painful for them to face what has happened to their child. These situations can affect a parent's ability to emotionally support their child and protect them from future harm.

It is important to ask the parents how they view the child's role in the crime. Even when a child or adolescent could not have prevented a crime, sociological and cultural factors can influence attributions of responsibility. Older children and teenagers are often viewed as having made a greater contribution to crimes against them than younger children. Parents are more likely to attribute responsibility to a child or adolescent victim when the offender is a family member and less responsibility when the offender is a stranger. Parents are frequently angry at child and adolescent crime victims when their actions (such as misbehavior, defiance of rules, or substance use) played a role in increasing the child's vulnerability to the crime. Although this must be handled sensitively, parents and caregivers should be asked whether they consider the child to be responsible for any aspect of the crime.

It is also important to ask whether the parents or caregivers blame themselves in any way. Understanding the caregiver's beliefs about their role in the crime helps to identify the therapeutic interventions needed to assist them in supporting the child's recovery. Do they believe they could have done anything differently to protect their child from harm? Self-blame is common in caregivers of traumatized children, although their feelings are often not realistic. However, some caregivers contribute to their child's trauma through direct action, poor judgement, or other limitations.

One of the most important factors in a child's recovery from traumatic events is their ability to obtain emotional support from others, especially parents and caregivers (Cohen & Mannarino, 1996, 1998; Browne & Finkelhor, 1986). A child's crime-related symptoms (such as fears, nightmares or bedwetting) may be disruptive to the

normal family routine, straining the parent's energy and reducing empathy toward the child. Find out how parents and family members responded to the child after the discovery or disclosure of the crime. Of particular concern is the caregiver's ability to tolerate their child talking about memories and feelings regarding the traumatic event. Caregivers should be discouraged from interrogating a child about a crime, but they should be encouraged to listen supportively when the child initiates discussion about the topic. The child should not be made to feel that talking about the crime is something to be avoided or ashamed of.

The caregiver's expectations regarding treatment should be assessed. How long do they expect therapy to take, how frequently do they expect the child to be seen, and how soon do they expect to see improvement? Discuss how much the caregiver expects or wants to be told about what happens in the child's sessions. This information helps the evaluator to form an opinion about the caregiver's ability to support therapeutic intervention and identifies how much feedback on progress will be beneficial. If children are cared for by foster parents or relatives, find out how they view their role. Do they expect their caregiving to be short-term or long-term? Do they support the child's reunification with the biological parents, or do they hope to become the child's permanent caregiver? Are their desires consistent with the likely outcome of the case? Discrepancies in such goals should be addressed in the overall case plan and treatment recommendations.

It is important to assess the caregiver's capacity to protect the child from further harm. Do they fear retaliation from the offender? Are their worries realistic? Children and their caregivers may fear an incarcerated offender even when the risk of future harm from that offender is minimal. With intrafamilial or known offenders, fears of future harm may be realistic and can require implementation of appropriate safety plans. Family pressures and divided loyalties in intrafamilial cases can impair a caregiver's ability to obey court orders and to implement restraining orders. The evaluator should discuss with the caregivers whether any fears or family pressures might interfere with their ability to protect the child. Some caregivers understand the child's need for physical safety, but not the concept of emotional safety. The evaluator should also ask whether their phone conversations or discussions about the crime with family or friends could be overheard. Generally, children become anxious when overhearing crime-related conversations.

Assessment should include observation of child-caregiver interaction during a conjoint session or informally by observation in the waiting room. The evaluator observes how the caregiver interacts with the child and how the child functions in relationship to the caregiver. The evaluator must assess the caregiver's ability to provide nurturance and support while also setting age-appropriate boundaries and limits on behavior.

Assessment of Parent Psychological Functioning

Some parents of child crime victims experience serious psychological symptoms (such as depression or post-traumatic stress symptoms) that either begin (or are exacerbated) in response to their child's victimization. Mothers of sexually maltreated children may be especially at risk and their own symptoms can influence how they perceive their children's functioning (Newberger et al., 1993), as well as their ability to be emotionally available to support their child (Pithers et al., 1998; Conte & Schuerman, 1987; Newberger & De Vos, 1988). A recent study of 92 female caregivers of maltreated children in outpatient treatment found that biological mothers had significantly higher levels of psychological symptoms (PTSD and depression) at intake than did relative caregivers or foster mothers (Winterstein & Aguila, 1999). Many mothers in the group had their own undisclosed maltreatment histories. The task force suggests the use of thorough psychosocial interviews and standardized measures with parents of traumatized children to aid in assessing the caregiver's own needs for therapeutic intervention. See Appendix A for more information.

Assessment of Caregiver Interaction with Child Welfare and Court Systems

The evaluator should talk to the caregiver about what agencies have become involved in the child's life since the crime occurred, such as medical personnel, law enforcement, child welfare agencies, and various courts. Determine where and when the child has been interviewed, by whom, and for what purpose. Ask about how the child has reacted to these experiences. Does the caregiver understand the roles of different social agencies? For example, caregivers often report that a child "has to go to court" but don't know which court

(criminal, juvenile dependency, or family court). Can the caregiver explain the status of the child's involvement in each of the relevant court settings? Will either the child or the caregiver be required to testify in court proceedings? It is important to help families obtain support and advocacy services to assist them in coping with the court process. Caregivers may view all social service and governmental agencies as "One Big System" and assume that information given to one party is automatically provided to all others. This belief can lead to misunderstandings between parents and clinicians. For example, a parent may call a child welfare worker to cancel an assessment appointment, incorrectly thinking that the mental health provider will automatically receive the information.

Children are influenced by their parents' reactions to law enforcement and social service personnel. Assess how the parent or caregiver feels about and copes with the participation of social service and governmental agencies in their daily lives. Caregivers may have intense feelings, both positive and negative, toward these systems. Even parents who desire to cooperate fully with a criminal prosecution may become stressed and frustrated. In crimes with intrafamilial offenders, parents face the additional burden of child welfare agencies coming into their home to evaluate their fitness. Parent's relationships with these agencies can influence the child's emotional reactions to other helping professionals.

Family Members (Siblings, Extended Family)

The initial assessment should gather information about siblings or other family members who may have been affected by the crime. Do they require mental health treatment? How supportive are they toward the child victim? Has foster placement separated the child from significant and potentially supportive family relationships? Whenever possible, a child or adolescent's supportive relationships should be maintained. If siblings or other family members have participated in the crime as offenders, the initial assessment should determine which types of contact (none, monitored visits, phone calls from jail which violate court orders, and so on) are occurring between the child and their offender, and the psychological impact of such contact on the child.

Collateral Contacts (Teachers, Pediatrician, Child-Care Provider)

Parents or foster-parents are often focused primarily on crime-related stressors and a child's functioning at home. Collateral contacts such as the child's pediatrician or teacher can provide a different perspective on a child's strengths and difficulties. Pediatricians can provide valuable information regarding a child's medical history, medications, current health status, and functioning prior to the crime. Teachers observe children interacting with classmates and with adults who are not their family members. Teachers can be asked for their impressions of how the child functions academically, emotionally, behaviorally and socially. It is important to assess whether crime-related symptoms observed in the home are also seen at school. The teacher may be willing to complete standardized measures describing the child's classroom behavior.

When preparing for collateral contacts, confidentiality issues must be addressed. Clinicians need to be clear about what information they are allowed to disclose to teachers. Many parents or caregivers are reluctant for teachers to have information about their family or a child's crime history, fearing the child will be stigmatized or that confidential information will end up in permanent school records. Many caregivers allow teachers to discuss the child's school functioning but do not want the clinician to provide information to the teacher regarding case history or diagnosis. Clinicians should avoid psychological terminology when communicating with teachers.

Standardized Assessment Instruments

Many clinicians use projective assessment methods in diagnostic evaluations of traumatized children (for example, Rorschach, House-Tree-Person, Kinetic Family Drawing, and so on). While these can be clinically useful, their interpretation is subjective and depends on specialized clinical training and expertise beyond that of many treatment providers. Such instruments do not readily allow comparison between traumatized children and other groups, or of the same client at different treatment intervals. A discussion of the potential benefits of projective assessment methods is beyond the scope of this task force.

There is no single structured interview or standardized test instrument that is universally accepted for making a diagnosis of PTSD in children, although the Clinician Administered PTSD Scale for Children and Adolescents (CAPS-CA) is being evaluated in several populations with high rates of traumatization (see Appendix A). When assessing children, it is important to integrate clinical information from at least three sources whenever possible. Parents tend to underreport PTSD symptoms in their children because they are often unaware of internal reexperiencing symptoms such as intrusive thoughts. Although children are better able to describe their own reexperiencing symptoms, they tend to underreport avoidant and numbing symptoms, such as dissociation. Teacher report measures provide valuable information on concentration and school functioning, but are likely to miss symptoms that are not problems during the school day such as sleep disturbance, nightmares or nighttime enuresis (Handford et al., 1986; Malmquist, 1986; Rigamer, 1986).

Clinicians are encouraged to use a combination of standardized measures to strengthen the diagnostic assessment process, the choice of measures to be commensurate with each clinician's training and experience. There are a number of measures which are economical, fast and simple to administer, and which can be scored and interpreted by a range of mental health providers. These questionnaires or self-report inventories are completed by parents or caregivers, or by the child, depending on age. Such measures can assist the clinician in identifying symptoms or problems that may not be fully revealed in initial diagnostic interviews. They can also assist in identifying the frequency, intensity or duration of symptoms. The administration of standardized measures at repeated intervals in treatment can be useful in monitoring a child or caregiver's treatment progress. See the chapter on "Evaluating Treatment Outcome" and "Appendix A" for information about standardized measures considered useful by members of this task force in assessing traumatized children and their families.

Diagnosis and Treatment Plans

The goals of assessment include an understanding of the young crime victim's problems and an initial diagnosis that leads to the development of a treatment plan. The task force recommends a five-axis DSM-IV diagnosis, although it recognizes the limitations of the DSM-IV when diagnosing young children. For children ages birth to three years, the Diagnostic Classification system for Zero to Three, published by the National Center for Clinical Infant Programs in Washington, DC, may be helpful (Zero to Three, 1994).

Treatment plans should include measurable goals and interventions that are consistent with the diagnosis. They should include both trauma-specific treatment interventions and other interventions as required for preexisting problems or co-occurring conditions. Frequency and modality of sessions, type of treatment (cognitive behavioral, play therapy, pharmacological), and collateral treatment interventions (parents, siblings) should be described. Finally, the child or adolescent's primary caregiver (and the young victim, as developmentally appropriate) should receive feedback about the assessment findings and should be a participant in the development of the treatment plan.

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